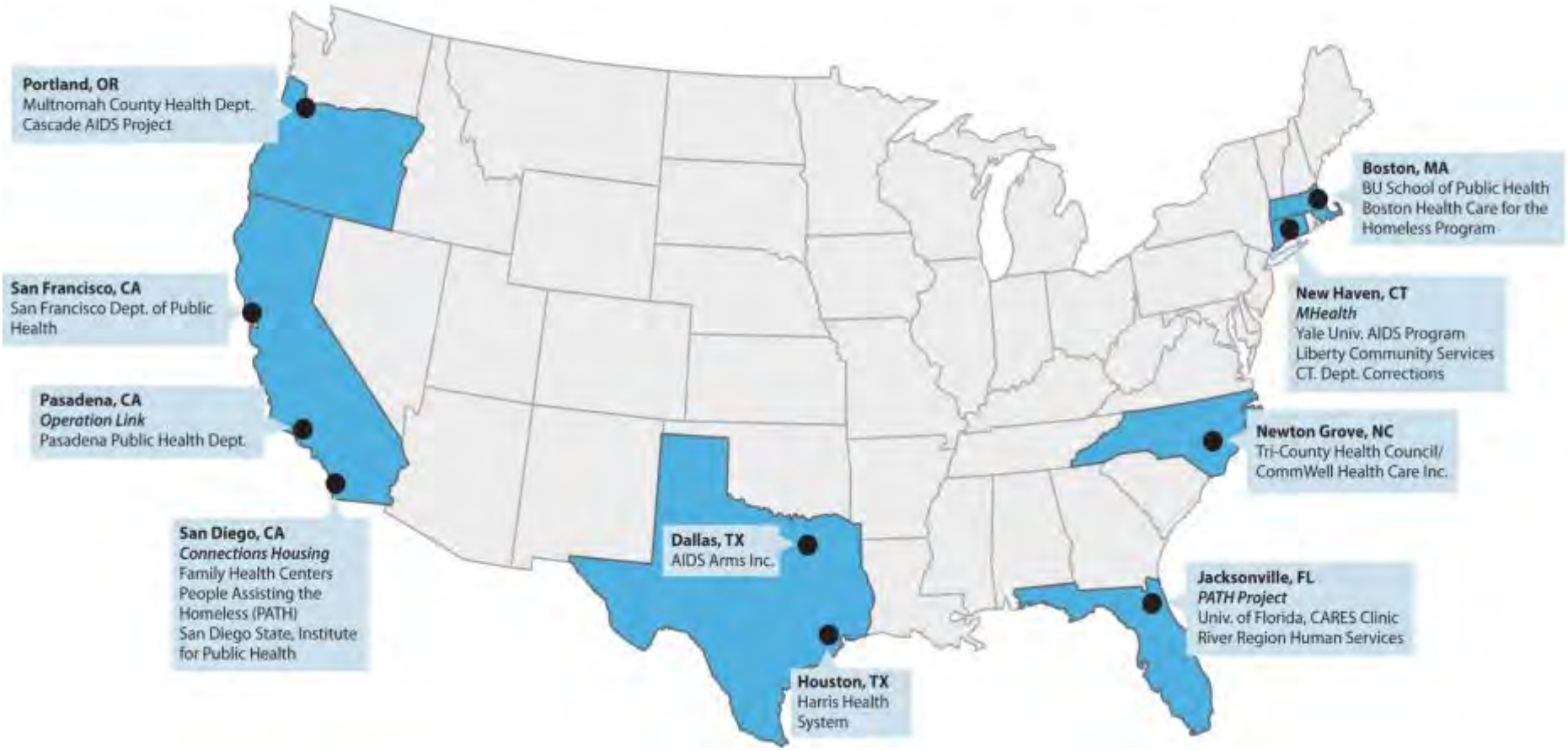
Building a Medical Home for multiply diagnosed HIV homeless/ unstably housed populations

HRSA, HIV/AIDS Bureau, Special Projects of National Significance

HRSA/SPNS Initiative: Building a Medical Home for HIV Homeless Populations



Goal: To engage homeless/unstably housed persons living with HIV who have mental illness and/or substance use disorders in HIV and behavioral health care and obtain stable housing

Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Describe the complex needs of people living with HIV who experience homelessness or are unstably housed.

2. Develop strategies to build staff skills and create external partnerships to facilitate care and services.

3. Create strategies, resources, and tools to provide integrated care

4. Identify approaches to use Ryan White funding, create partnerships with housing, behavioral health care and other community agencies, and generate other resources that can sustain medical homes and housing for persons living with HIV who are homeless/unstably housed.

Disclosures

Serena Rajabiun, Boston University School of Public Health, Boston, MA

Lisa McKeithan, CommWell Health, Dunn, NC

Deborah Borne, San Francisco Department of Public health , San Francisco , CA

Luis Moreno AIDS Arms Inc., Dallas, TX

Presenter(s) have no financial interest to disclose.

This continuing education activity is managed and accredited by Professional Education Services Group in cooperation with HSRA and LRG. PESG, HSRA, LRG and all accrediting organizations do not support or endorse any product or service mentioned in this activity.

PESG, HRSA, and LRG staff has no financial interest to disclose.

Providing care to people who are homeless/unstably housed: Barriers & Facilitators to achieving the National AIDS Strategy goals

Workshop 101

Serena Rajabiun, Boston University School of Public Health
Lisa McKeithan, CommWell Health
Deborah Borne, San Francisco Department of Public Health
Luis Moreno, AIDS Arms Inc

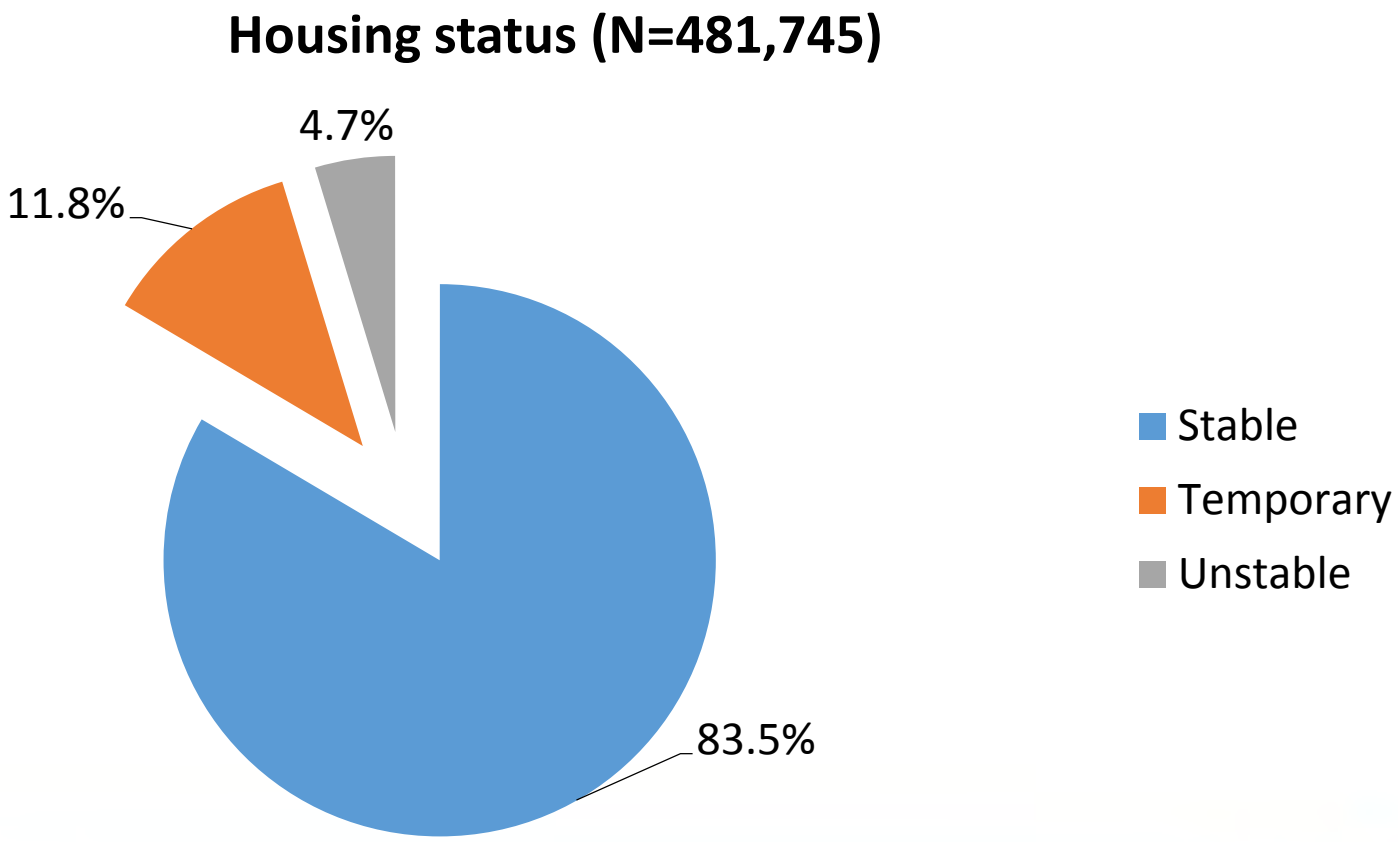
Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Describe the complex needs of people living with HIV who experience homelessness or are unstably housed

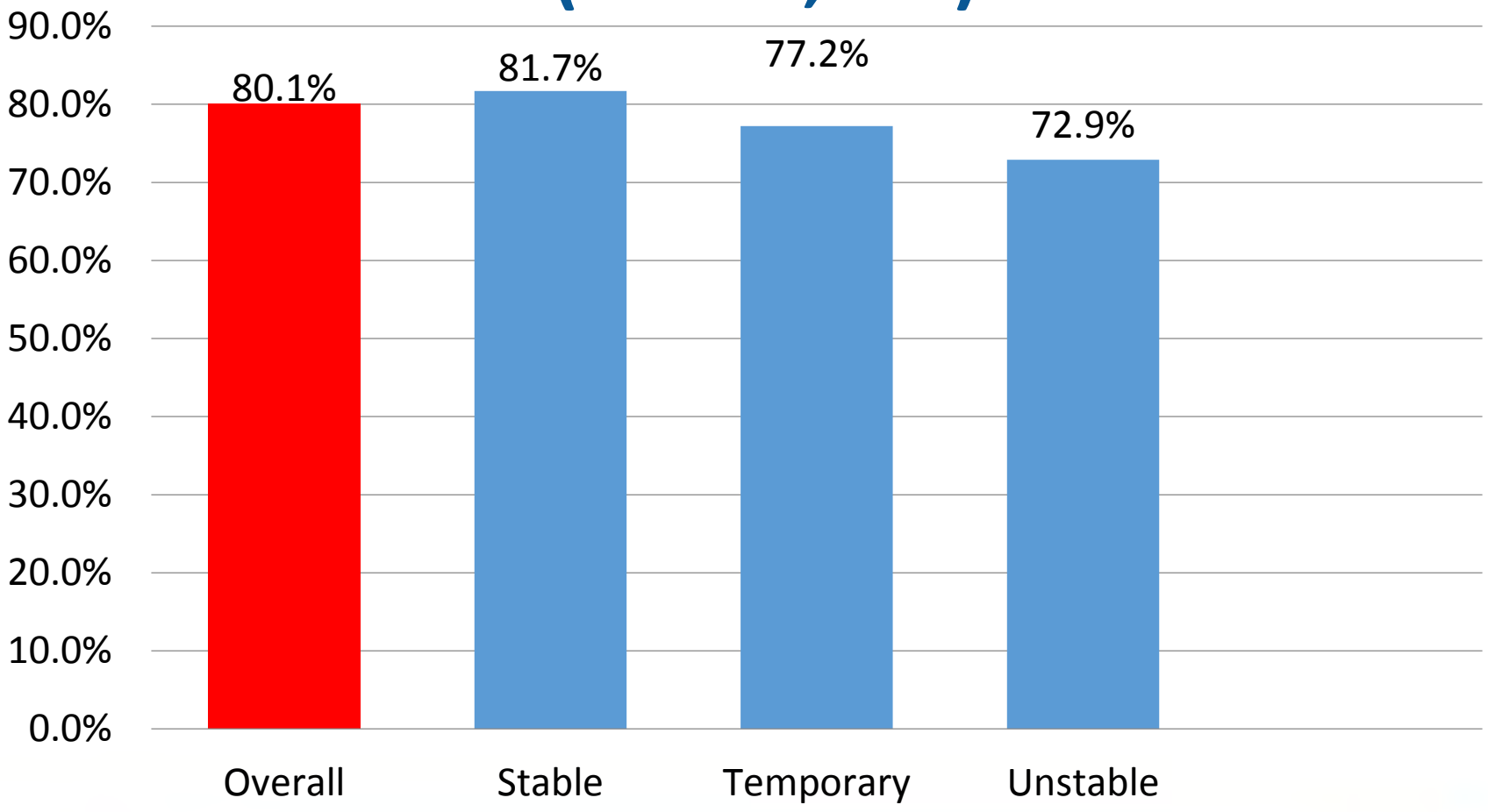
2. Create strategies to address the challenges at the individual, provider and system levels

Housing Stability among RWAP Clients



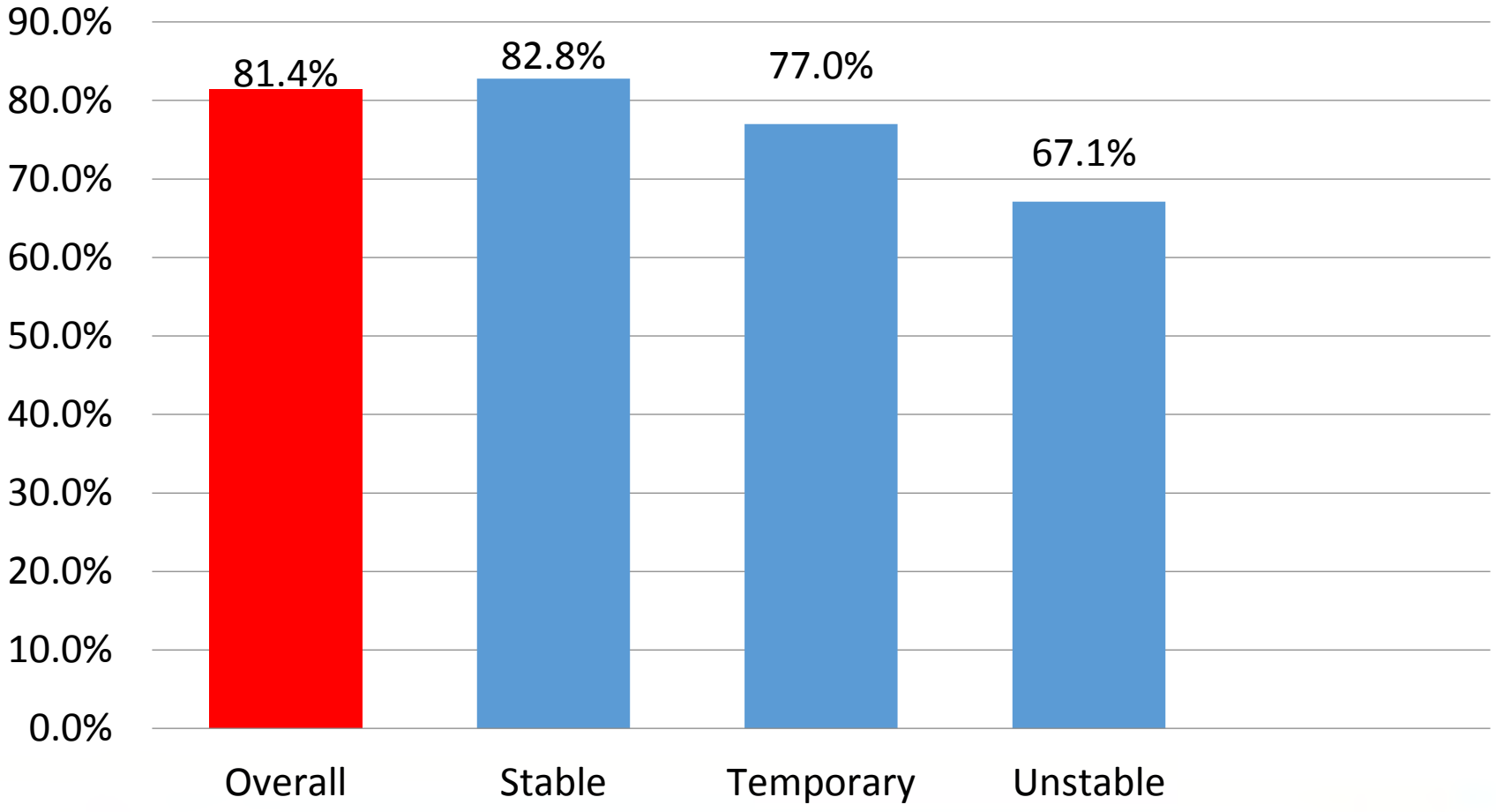
https://www.careacttarget.org/library/2014-rwhap-annual-client-level-data-report

Housing Stability & Retention in Care (N=272,193)



https://www.careacttarget.org/library/2014-rwhap-annual-client-level-data-report

Housing Stability & Viral Suppression (N=283,811)

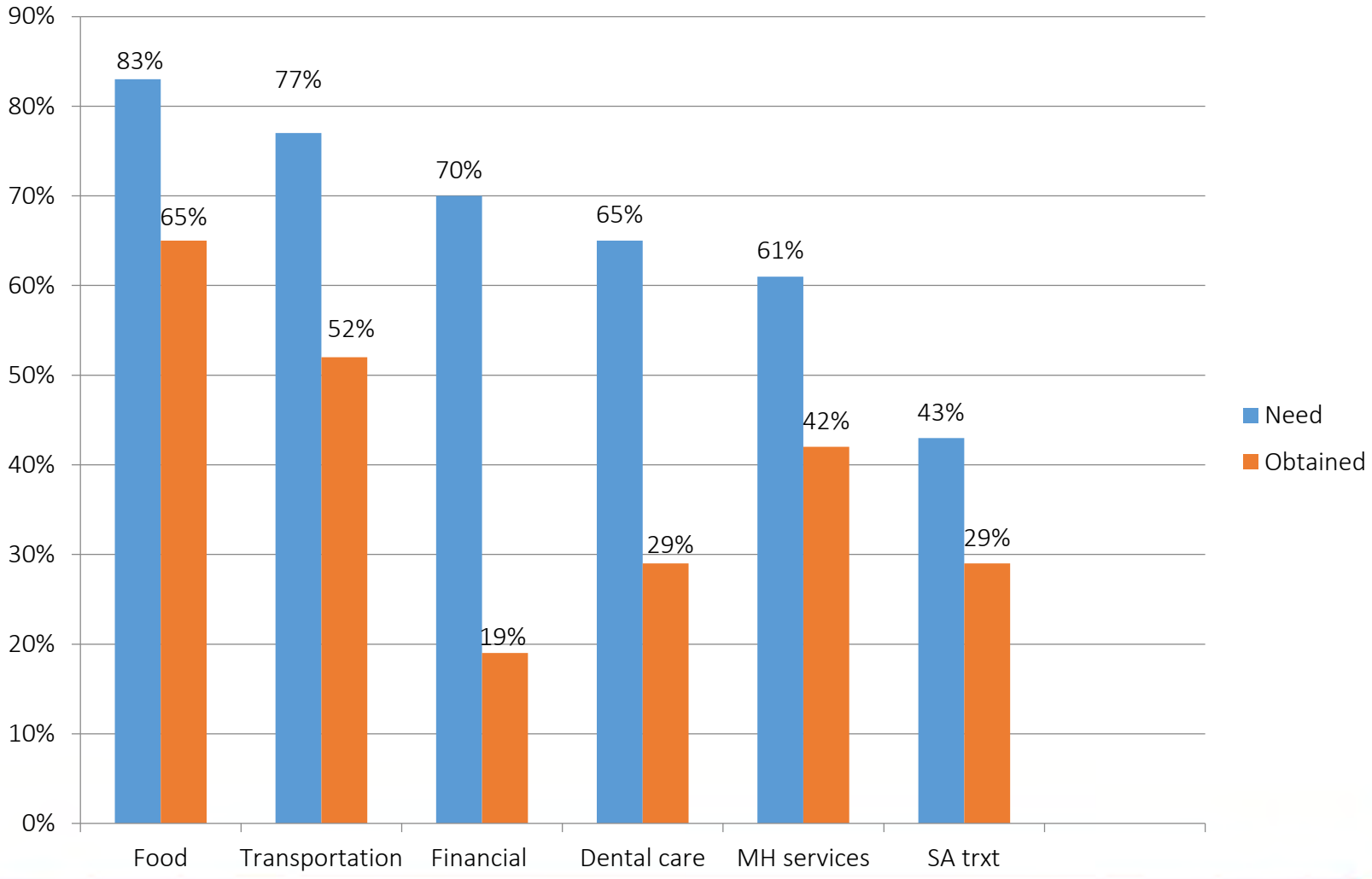


https://www.careacttarget.org/library/2014-rwhap-annual-client-level-data-report

Definition of Homelessness

- **Literally homeless**
  - Lacks a fixed, regular, and adequate nighttime residence
- **Unstably housed**
  - No lease, ownership interest or occupancy agreement in permanent and stable housing) in the last 60 days; or
  - Persistent housing instability as measured by two moves or more in the preceding 60 days; and
  - Expected to continue as such for an extended period of time.
- **Fleeing domestic violence**
  - Fleeing or attempting to flee domestic violence, has no other residence and lacks the resources to obtain permanent housing.

Service Gaps (n=909)
Number of unmet needs= 4



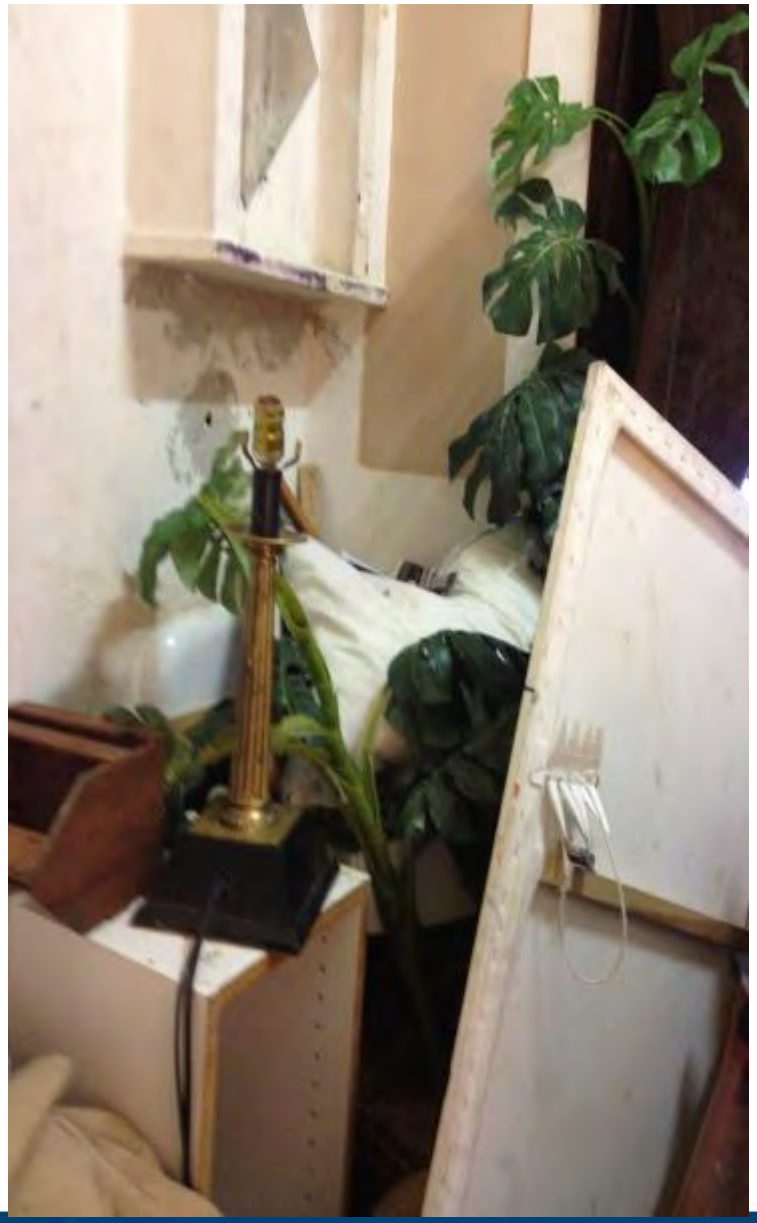
Barriers to care (n=909)

	%
No transportation to get to care	37%
Too depressed	36%
Did not want to go	31%
Not like to make appts too far in advance	27%
Could not pay for medical care	25%
Too sick	23%
Not sure where to go	22%
Number of reported barriers (average)	**3**

NC REACH Client Story

http://medheart.cahpp.org/sites/default/files/CommWell-Client-Story.mp4

Barriers to care experienced by people living with HIV who are homeless/unstably housed



Challenges to Engagement and Retention

Trauma: Homelessness and Sanctuary Trauma

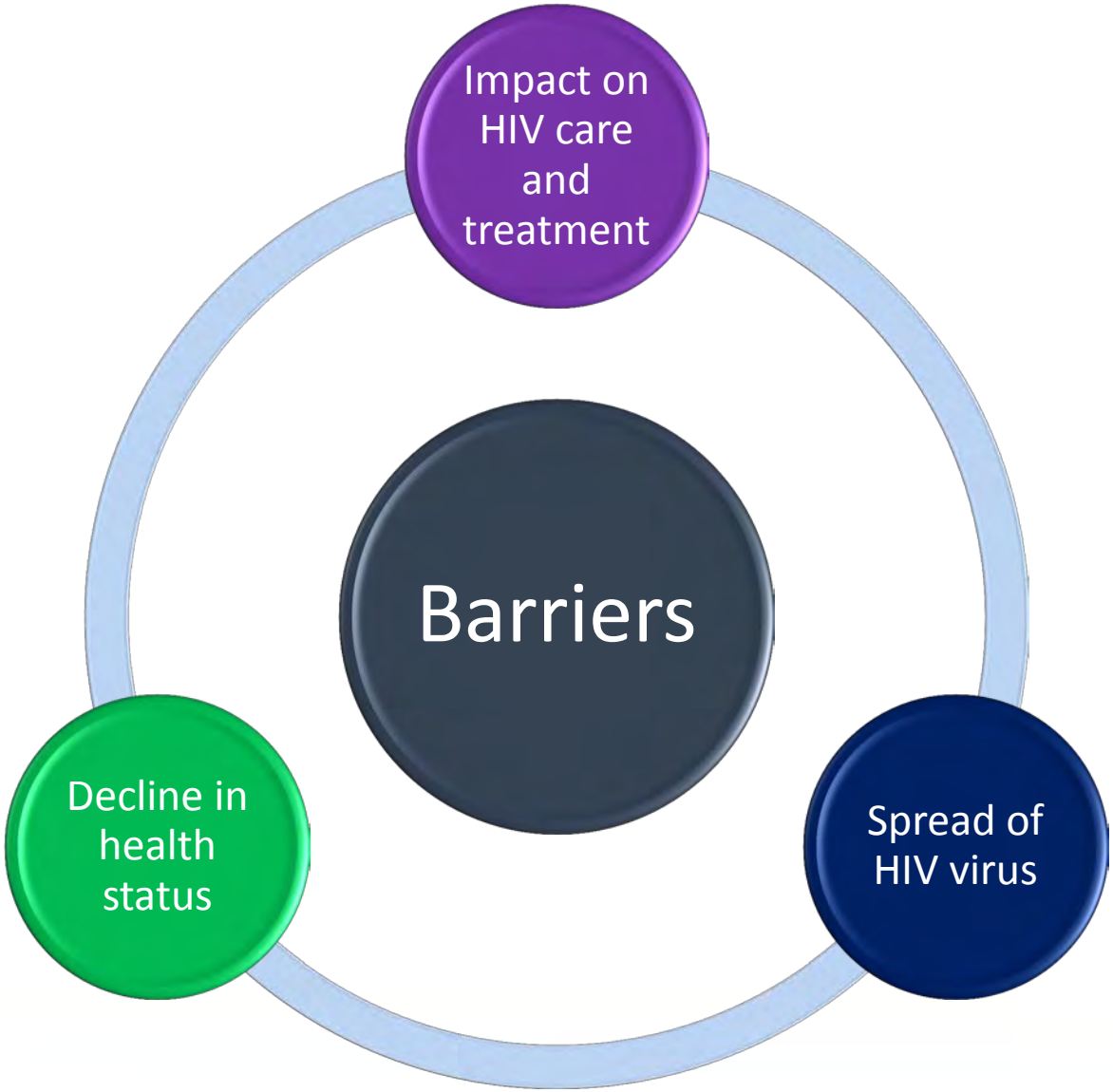

DO NOT DISTU

Housing Instability in Rural Areas

- Homelessness
- Unstably Housed

Barriers to Retention in HIV Care in Rural Communities

- **Housing instability**
- Transportation needs
- Substance abuse
- Mental health
- Provider discrimination
- Stigma
- Lack of financial resources
- High no-show rates
- Lost to care and out-of-care


Impact on HIV care and treatment
Barriers
Decline in health status
Spread of HIV virus

Homeless PLWH – Needs

- Trauma history and persistence
- Substance use or abuse specifically Meth
- Mental Illness
- Multiple co-morbidities, physical disabilities and unaddressed health and other conditions/concerns
- Resistance to engaging in care and treatment

Homeless PLWH – Barriers

- Lack of trust
- Difficulty maintaining contact
- Hunger and dehydration
- Lack of identification/documentation
- Lack of transportation
- Poor or no access to sanitation resources
- Extremes in temperature

System Challenges to house and get people into HIV care and treatment

System Challenges

- Not enough stabilization or supportive housing
- Lack of trauma-informed programs and providers.
- Communication between hospital-hospital and hospital-community
- Not enough medical CM programs to ‘step down’ to.
- Data Issues: Different data systems
- Political environment constantly changing

System Challenges in Rural Areas

- Transportation
- MH/SA treatment
- Limited resources- housing units, transitional housing
- Services for homeless but not HIV+
- Red tape- background checks, drug screens
- Funding (Cost for emergency shelters)
- Duplication of services
- Few housing providers
- Lack of permanent, affordable housing
- Fragmented system
- Poor coordination of services

Serving Homeless PLWH – Systems Challenges

Inadequate:

- Available housing
- Adoption of housing first model
- Availability of providers with sufficient knowledge and understanding regarding needs of homeless individuals
- Availability of public transportation

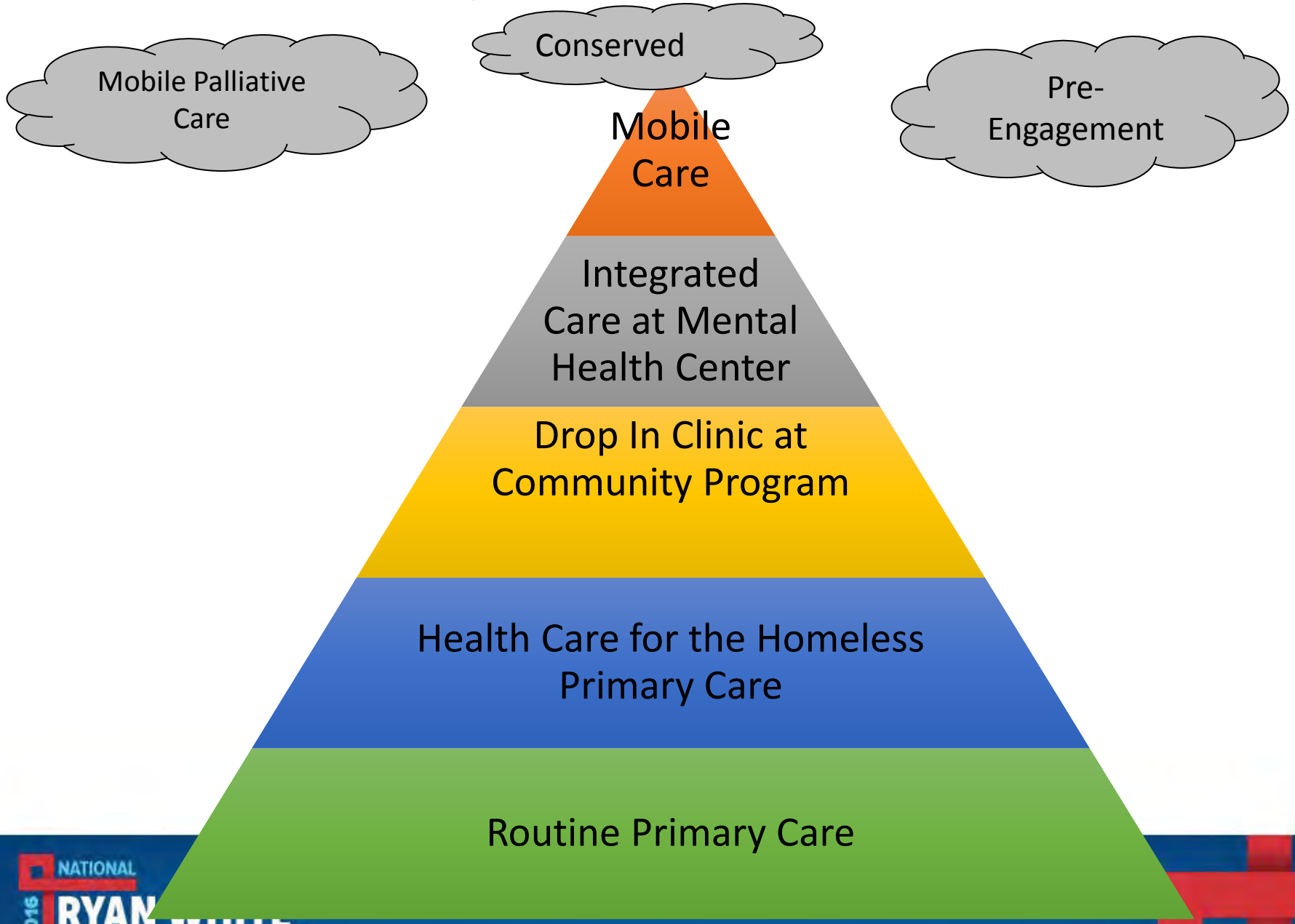
Strategies and Approaches to Providing Care and Addressing Barriers

Essentials Of Homeless HIV Health Care

Essential Services for Homeless & Marginally Housed HIV + Individuals

Team Based Primary Medical Care	Medical Case Management:	Office Based RN Care Coordination and Adherence
Integrated Behavioral Health Treatment	Addiction Medicine: Office Based Opiate Treatment	Shelter Health and Wellness
Dental Care	Housing: Stabilization and Permanent Supportive	Respite Care
Benefits Acquisition	HIV Prevention: LINCS coordination *'for Lost Clients'*	Quality Improvement: Chronic Disease Management

Levels Of Primary Care for HIV Positive Homeless Clients



How is Homeless Care Different from 'Typical' Ryan White Service

- Providers must work with a team
- Care:
  - Trauma-informed
  - Client-centered
  - Strengths-based
  - Harm reduction
  - Recovery model
  - System-supported
- Medical Advocacy

NC REACH:
SPNS Program at CWH

- Innovation
  - Build and maintain sustainable linkages to mental health, substance use treatment, and HIV/AIDS primary care services that meet the complex service needs and ensure adherence to treatment of HIV positive homeless or unstably housed individuals.
    - Network navigators
    - Behavioral health
    - Housing services
    - Comprehensive care coordination team (Positive Life Program)

Role of the Network Navigator

- Connects to community housing and other support services
- Participates in the multidisciplinary clinical team
- Provides supportive services to clients to maintain housing and reduce risky behaviors
- Makes relevant supportive programs available for clients
- Serves as a liaison between the client and the landlords

Health Hope and Recovery – Program Model

Care Coordination provided by three full-time experienced social workers. It includes:

- Use of motivational interviewing and strengths-based counseling to engage clients in identifying goals related to housing, medical care, mental health and/or substance use treatment.
- Frequent meetings with clients to address barriers to accomplishing goals.
- Significant collaboration with medical providers, pharmaceutical assistance programs, housing resources and others to connect clients with critical resources.

Health Hope and Recovery – Program Model

Also includes:

- Providing supportive services to clients to maintain housing and reduce risky behaviors.
- Making relevant supportive programs available for clients such as the HIVE, WRAP groups, etc.
- Providing ongoing advocacy on behalf of clients.
- Ensuring that clients are receiving appropriate and respectful care.
- Enabling clients to build resiliency.

System Approaches

SYSTEM WRANGLER

Acuity and Chronicity Assessment

Mobile Medical

Case Management

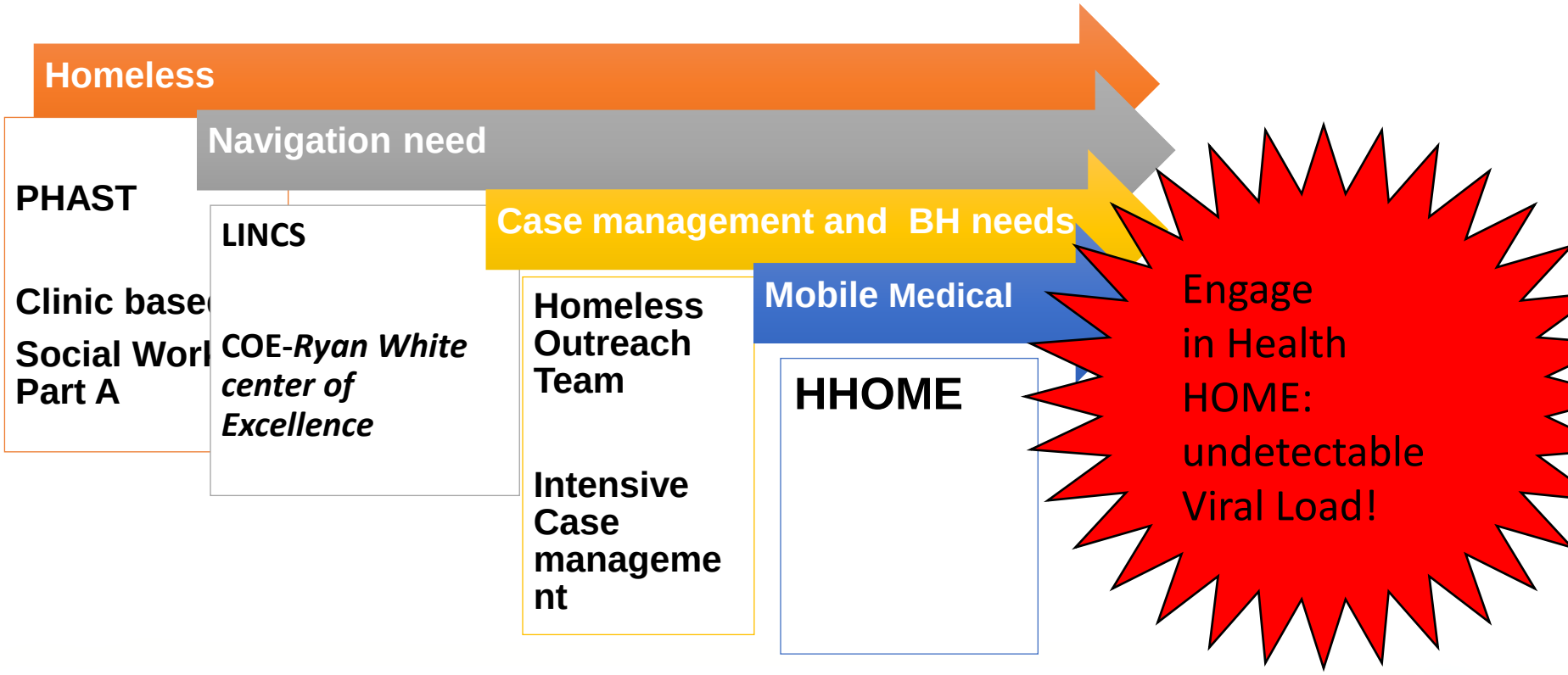
HOUSING

HHOME TEAM

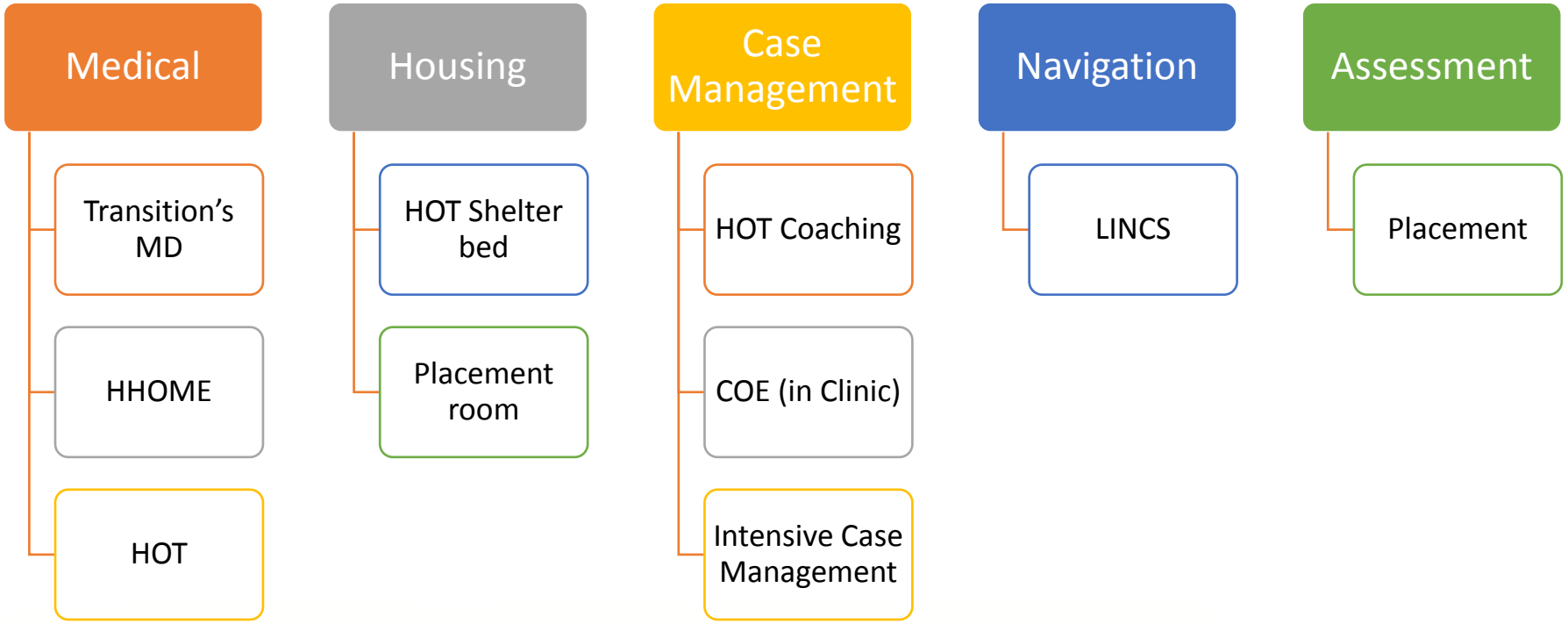
Behavioral Health

Navigation

Levels of Support Based on Need for Difficult-to-Engage Homeless HIV+ Clients



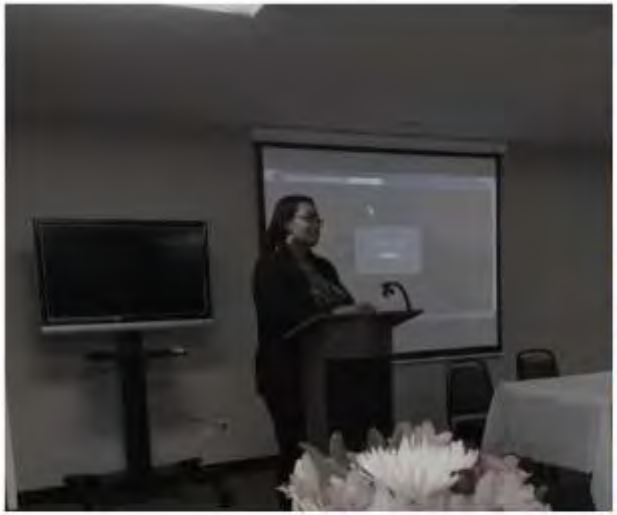
Cross-Agency Support for Gaps in Service for Level of Care



Community Housing Coalition

- Forum for local housing providers
- Quarterly meetings
- Development of shared goals and objectives
- Venue to share resources
- 2-way street: Connecting clients to housing and medical

Community Housing Coalition



Community Outreach

Health Hope and Recovery Strategies

AIDS Arms has made concerted efforts to:

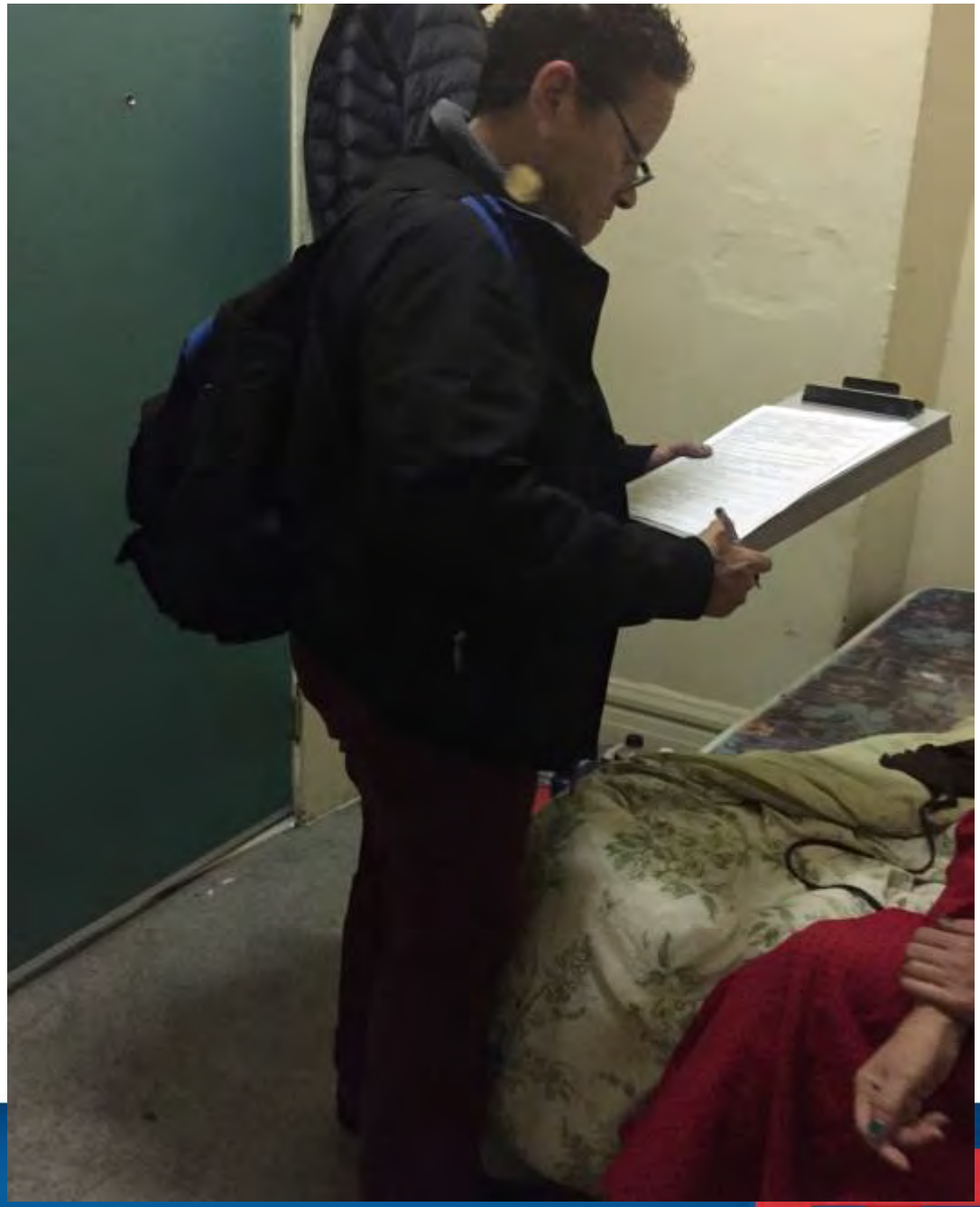
- Improve communication with providers serving the homeless clientele in order to ensure appropriate, adequate care
- Refine and strengthen internal procedures and protocols regarding serving the homeless population
- Inform providers about client needs
- Educate internal and external providers about trauma-informed care
- Promote the use of the Housing First model

Tools & Resources

What Works: Tools

"Never Give up Never Surrender"

- *Siotha King-Thomas*



Our Approaches

Creative Approaches to Adherence

What Works

- Team communication
- Flexible treatment plans
- Cross training of team
- Starting treatment anywhere, anytime
- Insist on the best quality of care
- Community pharmacy
- Courage of consumer and team

Consumer Sets the Treatment Plan

Tools and Resources

AIDS Arms has worked toward making the following resources available for Health Hope and Recovery clients:

- Emergency housing
- Cell phones
- Monetary assistance for document replacement
- Safe storage of key documents
- Basic resources for survival
- Acceptance of client mail

Resources

LOCAL SERVICES INVENTORY FOR COMMWELL SPNS MEDICAL HOME PROJECT

GENERAL INFORMATION				SERVICES PROVIDED											
Name of Center	Key contact person	Location	Shelter	Housing assist	Substance use	Mental Health	Case Mgmt	Primary Medical Care Assistance	Meals Assistance	Domestic Violence	Financial Assista	HIV prevention	Social support	Other (specify)	Notes
Adult Health Clinic Harnett Co. Health Dept.	Debra Hawkins 910-814-6198	307 W cornelius Harnett Blvd Lillington NC	No	No	no	Yes	yes	Yes	no	No	no	Yes	no	N/A	
Alliance of AIDS services-Carolina	Stacy Duck 919-834-2437	324 S. Harrington st. Raleigh, NC	No	Yes	Yes	Yes	Yes HIV	Yes	Yes	No	Yes	Yes	Support	n/a	n/a
Beacon Rescue Mission	John Cooke 910-892-5772	207W. Broad Street Dunn, NC	Yes	yes	no	Yes	no	no	yes	yes	no	no	no	n/a	Homless shelter
Betsy Johnson Regional Hospital	910-892-1000	800 Teilghman Dr. Dunn NC	No	No	Detox by	Yes	no	Yes	no	No	no	Yes	yes	N/A	detox thru ER only
Carolina Outreach	Rhonda Nordin 910-438-0939	907 Hay St. Fayetteville NC	No	No	Yes	Yes	Yes	No	No	No	No	Yes	Yes	N/A	
Cape Fear Valley Behavioral Health services	Laura Taylor 910-615-3753	3425 Melrose Rd Fayetteville NC	No	Yes	yes	yes	yes	yes	no	no	no	yes	yes	n/a	
City Rescue Mission	Gladys Thompson 910-323-0446	120 North Cool spring st.	Yes	yes	no	Yes	no	no	Yes	yes	yes/ case by	no	yes	n/a	Female only cost$50.00/
Community Health Interventions	Elazzoa McArthur 910-488-6188	2409 Murchinson Rd Fayetteville NC	No	No	no	no	yes	no	no	no	yes	yes	yes	n/a	
Christian Faith Ministries	Tabatha Franklin 919-776-8474	705 Chatham St. Sanford NC	Yes	No	no	no	no	no	Yes	No	No	no	Yes	n/a	Homeless shelter
Cumberland County Health	Phyllis McLemore 910-433-3600	1235 Ramsey St. Fayetteville NC	No	No	yes - by referral	Yes	no	Yes	no	No	no	Yes	n/a	N/A	
Cumberland Interfaith	Denise Jiles 910-826-2454	113 Stein St. Fayetteville NC	No	yes	no	no	no	no	Yes	no	no	no	no	n/a	In county only
Good Neighbor House for women	Karen Earp 919-934-3639	Smithsfield NC	Yes	Yes	no	no	yes	no	yes	yes	no	no	yes	n/a	Female only mandatory drug screen.
Healing Place of Wake County	Dennis Tripp 919-838-9800	1251 Goode St. Raleigh NC	Yes	Yes	no	no	Yes	no	Yes	yes	No	no	Yes	n/a	Out of County case by case
Hope Center	Evelyn Campbell 910-920-4729	913 Person St. Fayetteville NC	Yes	yes	yes	yes	yes	no	yes	no	no	yes	yes	n/a	cost $7.00/day
House of Fordham Shelter	Linda Burroughs 919-736-7352	412 N. William st. Goldsboro NC	Yes	Yes	no	no	no	no	Yes	No	no	no	y	N/A	no cost
New Life Mission church/shelter	Pastor Grace Kim 910-864-4678	303 Maloney Ave. Fayetteville NC	Yes	No	No	No	No	No	Yes	No	No	no	Yes	n/a	
Potter's Wheel Ministries	Manager John	147 Faith Ln. Mount Olive NC	Yes	Yes	No	No	Yes	No	Yes	No	No	No	Yes	n/a	
Port Crisis Center, Human Services	252-413-1637	203 Government cir. Geenville NC	No	No	yes/detox	Yes	yes	Yes	no	No	no	Yes	yes	N/A	Detox facility
Project Homeless Fayetteville PD	Officer Stacey Sanders Community	467 Hay St. Fayetteville NC	No	liason only	no	no	no	no	liason	liason	no	no	yes	N/A	homeless liason

Program Changes & Next Steps

Program Enhancements at AIDS Arms

- Subscription to HMIS
- Availability of pre-packaged food and water for clients
- Transportation assistance
- Cooling stations
- Mail acceptance
- Care coordination follows the client
- Ensuring warm hand-off to facilitate transition to 'standard of care’
- Increased staff education regarding how best to serve clients who are homeless

INTEGRATED MOBILE CARE: SPNS/HHOME Pulled System Gaps Together

Mobile Medical Case Management

Mobile RN Care Coordination and Adherence

Mobile Integrated Primary Medical Care

Timely Access to Medical Shelter, Stabilization Room and Respite

City Wide Evaluation for Level of Care for Clients

Coordination of community partners and services available to clients

Access to all city Supportive Housing (outside of DPH)

Integrated Patient HIV Registry

Fully Utilize Peer Navigators as part of care team

Ongoing Gaps

- Inadequate options for clients who have acute medical needs
- Hospitals discharging clients with ongoing medical needs to the street without necessary support
- Inconsistency regarding eligibility determination for permanent housing
- Staff turnover at service providers

Ongoing Program Challenges

- Not enough Navigation or RN time
- Not Co-Located
- Data issues:
- Applying "QI" principles to a moving target is tricky
- Maintaining calm focus in the midst of chaos
  - "If we weren't meditating before this, we certainly meditate now." -*Janell*
- Addressing short-term goals and long-term goals simultaneously
  - "[Hard to] zoom in and zoom out" – *Ilona*

Continued Need For Outreach For Prevention and Treatment

Support Needed for Learning Life Skills

Success

- Several participants are stably housed due to partnerships made through the **Community Housing Coalition**

Health Hope & Recovery Client Story

Video Link:
https://drive.google.com/open?id=0B9kKzN00i7KBaXNHODVZSnZCbVk

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For more information go to: http://cahpp.org/project/medheart/

RESOURCES

- https://www.nhchc.org/

- SAMHSA's SSI/SSDI Outreach, Access, and Recovery Technical Assistance https://soarworks.prainc.com

- http://www.samhsa.gov/nitt-ta/training-technical-assistance

RESOURCES

Coldspring Center
for Social and Health Innovation

- http://coldspringcenter.org

Center for
Social Innovation

- http://center4si.com

For more information at the Conference:

- Workshop 201: **Using interdisciplinary teams to provide care to people living with HIV/AIDS who are homeless/unstably housed**
  - Friday 8/26 @8:00 am
  - Location: Marquis Salon 15

- Workshop 301: **Leveraging resources to sustain programs for HIV care and housing for people living with HIV**
  - Friday 8/26 @10:00 am
  - Location: Marquis Salon 14