MULTNOMAH COUNTY HIV CLINIC

Building a Medical Home for PLWH Experiencing Homelessness

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Model Description…

Population: Persons living with HIV experiencing homelessness, mental illness and substance abuse in **Portland, Oregon**.

Intervention: Integrating **patient navigators** and housing support into a medical home model to better engage and retain clients in order to improve their HIV viral suppression and housing situation.

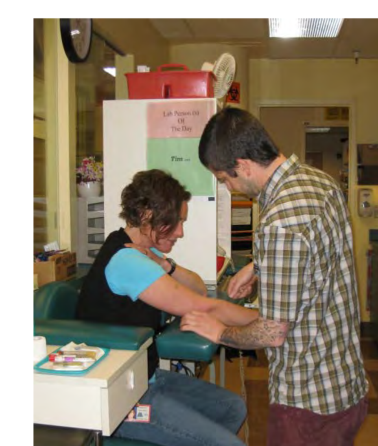
Desired patient outcomes:

- ❖ Patients attend medical and behavioral health appointments on a regular basis
- ❖ Patients take HIV and other meds as prescribed
- ❖ Patients gain housing
- ❖ **Patients achieve HIV viral suppression**

Partners and linkages: **Multnomah County and Cascade AIDS Project** were the lead partners.

A Little Context…

- ❖ The **Multnomah County HIV Clinic opened in 1990** as a Ryan White Part C grant recipient. The Clinic now also receives Ryan White Parts A, B and D funding.
- ❖ Certified as a **Patient Centered Medical Home** model in 2012.
- ❖ Is the largest HIV Clinic in Oregon, **serving over 1450 PLWH each year.**
- ❖ Provides patient centered team based primary and HIV specialty medical care with a focus on trauma informed care. **Other services include:** medical case management, mental health treatment, crisis intervention, High Resolution Anoscopy, Hep C treatment, art therapy, and adherence support.
- ❖ **Integrates behavioral health** into its service delivery model.



Key Lessons Learned…

- ❖ Keep your eye on **engagement in care and viral suppression**. For the chronically homeless client, learning to engage in care and adhere to medication regimes teaches valuable skills that are transferrable to things like getting and keeping housing.
- ❖ **Supervisory and management staff need to be flexible and nimble** enough to respond in real time to patient/navigator issues.
- ❖ **Start small.** Implement this new intervention with a small number of clients and grow the caseload slowly.
- ❖ Develop **strong partnerships** with agencies that add value to the process. Create detailed Memoranda of Understanding so that the partnerships are not based solely on staff-level relationships.
- ❖ Collect and **address feedback** from your medical team about the successes and shortcomings of the new navigation intervention. Everyone's input can help to strengthen navigation services and clinical outcomes of clients receiving navigation services.
- ❖ Approach the work with a **trauma-informed care** (TIC) lens. Decide what TIC means in the context of your organization and provide ALL staff with training.
- ❖ There is a great deal of abuse and **intimate partner violence** (IPV) in homeless populations. Be prepared not only to train your navigators and staff about IPV but develop protocols for navigators and other staff to handle IPV in the field and clinic.
- ❖ There are a lot of **"three steps forward, one step back"** working with PLWH who are experiencing homelessness. **Celebrate any success, no matter how small.**
- ❖ **Integrating housing case management** into the medical team will make a significant difference in getting clients with a multitude of housing barriers into stable housing situations.
- ❖ Be prepared to have your homeless clients drop in to clinic on a frequent basis. Have a **plan to triage their needs in REAL time.**
- ❖ If you are relying on one-time only funds to start your program, start figuring out how to **sustain the program** on day one. Integrate navigation into your regular budget by increasing billable hours or leveraging other funds on an ongoing basis.

The Navigators…

- ❖ Angie Kuzma, Patient Navigator
- ❖ Kristin Cedar, Housing Navigator
- ❖ Maurice Evans, Patient Navigator
- ❖ Jamie Christianson, Patient Navigator

Outcomes…

- ❖ 148 clients Served
- ❖ 70% of SPNS clients now housed
- ❖ 70% of SPNS clients are virally suppressed
- ❖ Navigation services will continue beyond the end of the project

Impact of integrating navigators into our patient center medical home…

- ❖ Viral suppression for all clients increased from 79% in 2012 to 87% in 2016!
- ❖ Clients with a suppressed viral load are living less chaotic lives and are deeply connected to their medical care teams

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