MULTNOMAH COUNTY HIV CLINIC
Building a Medical Home for PLWH Experiencing Homelessness
Maurice Evans, Jamie Christianson, Angie Kuzma, Kristin Cedar, Jo Ann Davich and Christa Black

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 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

Acknowledgments
This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number 5MH74249518 (Special Projects of National Significance (SPNS) Initiative Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations, in the amount of $1,480,860 awarded to Multnomah County HIV Health Services Center. Approximately 3% of this project was financed with non-governmental sources. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred from HRSA, HHS or the U.S. Government.