NC REACH: Outcomes Among Rural, Unstably Housed PLWHA Engaged in a Patient Centered Medical Home

Ayodele Gomih[1,2], Bahby Banks[1], Lisa McKeithan[3], Mirna Allende[3], Shalonda Pellam[3], Michaella Kosia[3], Stephanie Atkinson[3], Christopher Vann[3] Janet Stroughton[3]

[1]Pillar Consulting, Inc., [2]Department of Epidemiology, UNC Gillings School of Global Public Health, [3]CommWell Health

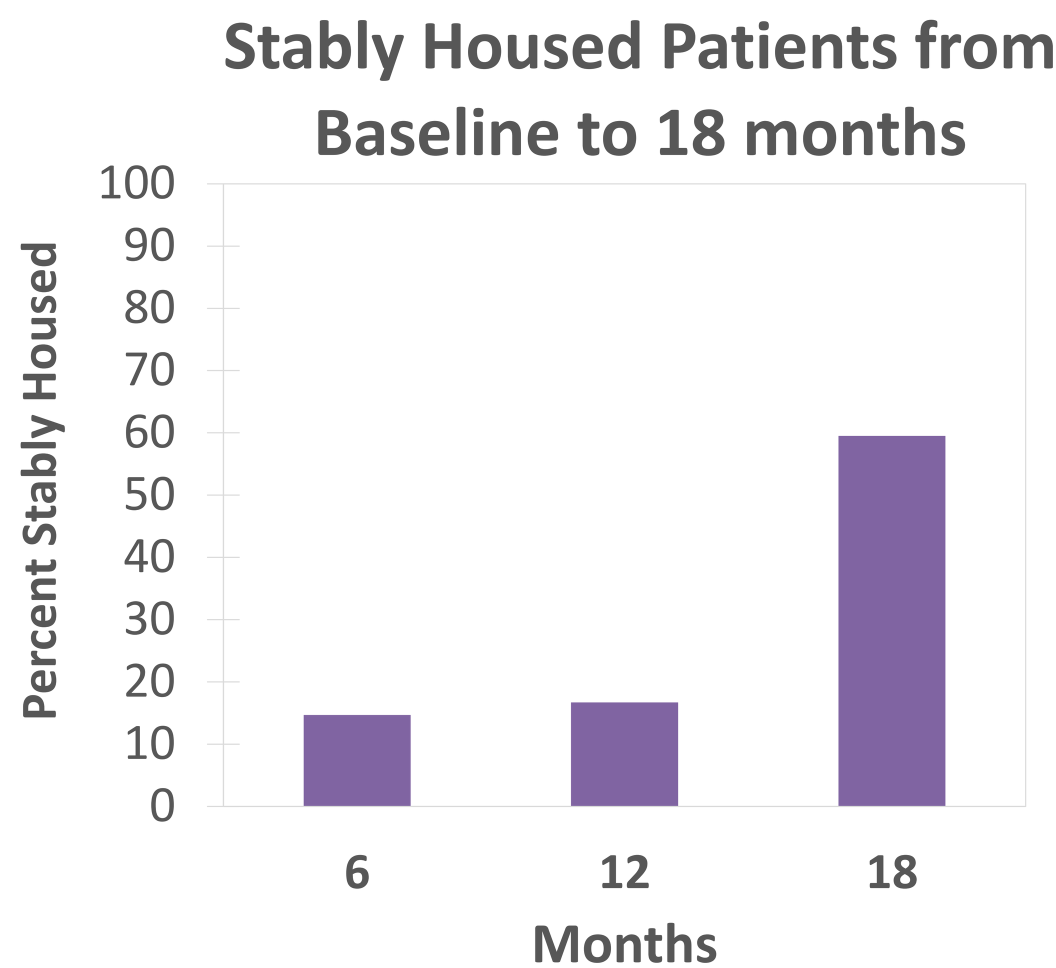
NC REACH is a demonstration project funded by HRSA's Special Projects of National Significance Initiative (SPNS). This project located in CommWell Health (CWH) combines the patient centered medical home (PCMH) model with the **Positive Life framework**, supplementing the standard of care with a **Network Navigator (NN)** and a **Continuum of Care Coordinator (CCC).** The **NN** works in partnership with patients to assure that all the medical and non-medical needs are meet. The **CCC** coordinates patient care across all elements of the health care system, while the **NN** connects patients to medical and supportive services in the community as well as housing assistance.

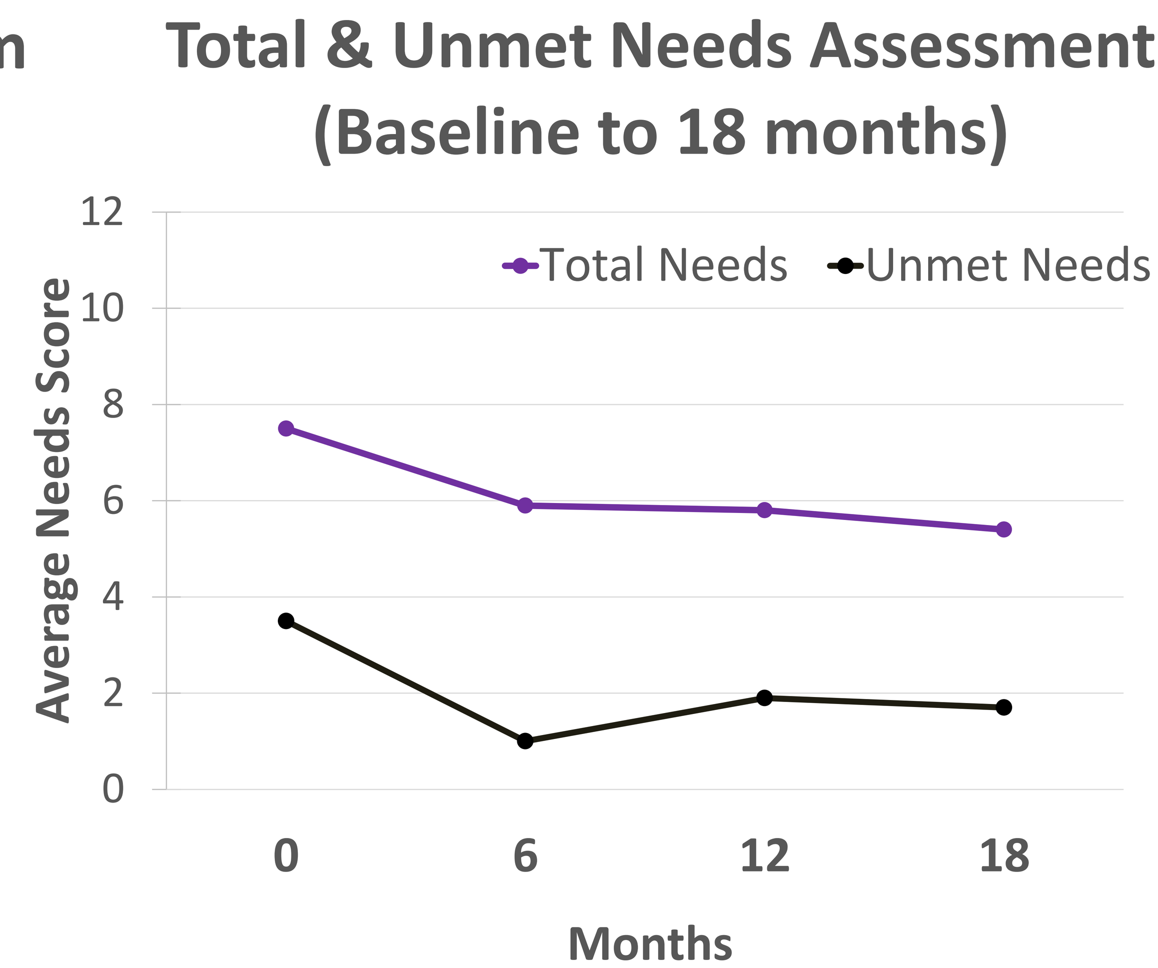
CWH is the *only* rural Community/Migrant Health Center in eastern North Carolina that manages Ryan White Part B, C and D funding. CWH offers comprehensive, culturally competent primary medical, dental and behavioral health care to persons living with HIV/AIDS (PLWHA) and is the largest provider of multidisciplinary HIV care in rural southeastern North Carolina. Collectively, these two innovative roles create a robust program for addressing homelessness, forging community partnerships and strengthening advocacy efforts in rural communities.

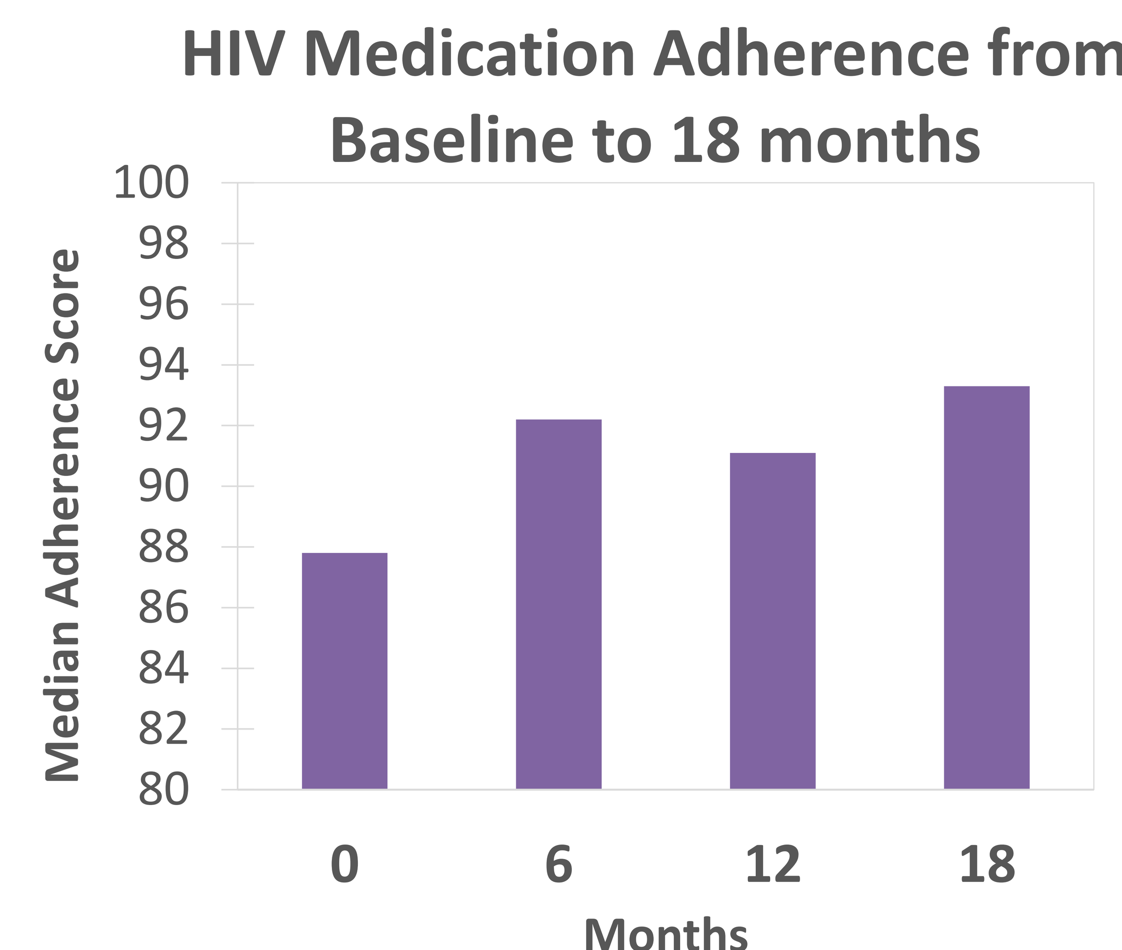
Baseline Characteristics (N=80)	n (%)
Age (years)	
≤30	26 (36.6)
31-54	45 (56.2)
55 +	9 (11.3)
Race	
Non-Hispanic Black	56 (70.0)
Non-Hispanic White	9 (11.2)
Hispanic	9 (11.3)
Other	6 (7.5)
Gender	
Male	52 (65.0)
Female	27 (33.8)
Transgender	1 (1.2)
Household composition	
Single individual	24 (30.0)
>1 adult and >1 dependent under 18	22 (27.5)
>2 adults and 0 dependents under 18	29 (36.3)
Other	5 (6.3)
Mean years since HIV diagnosis (range)	8.9 (0.1-27.1)

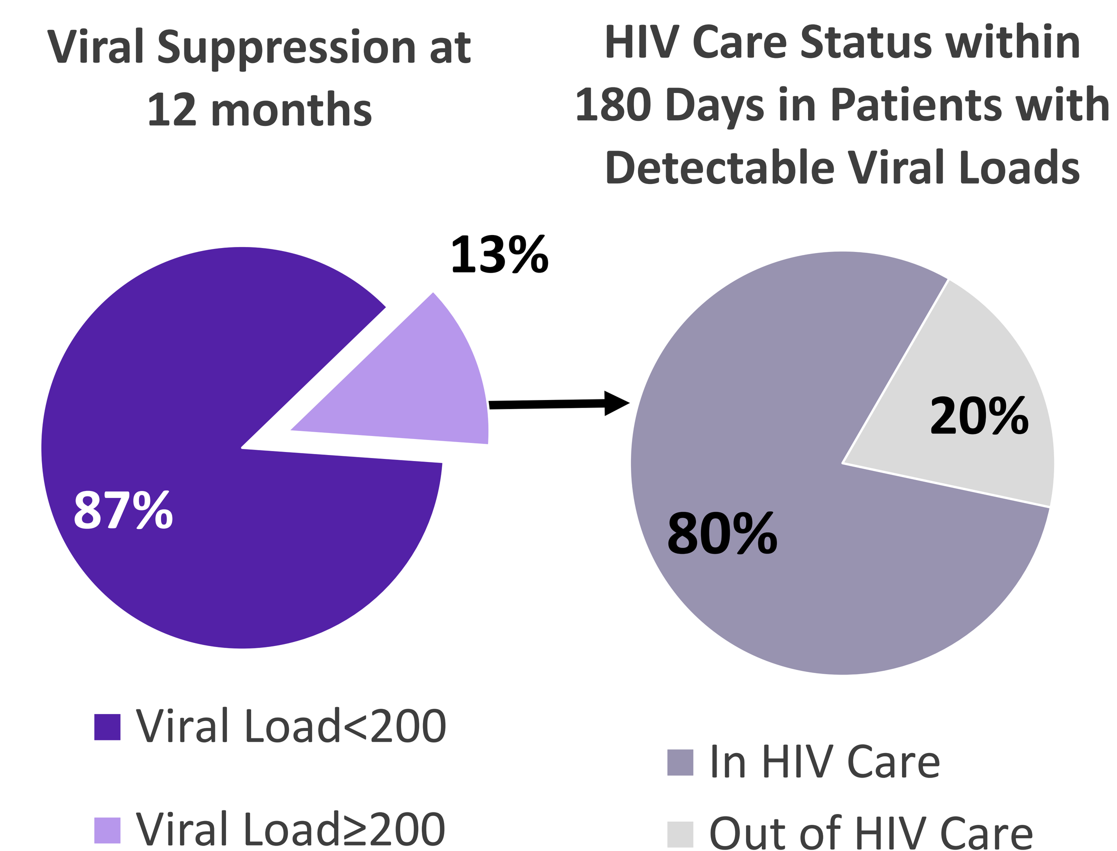
Program Characteristics	6 months n (%)	12 months n (%)	18 months n (%)
Engagement in Care	--	66(82.5)	--
Internal Mental Health Referral	64 (80.0)	48 (60.8)	26 (38.8)
Internal Substance Abuse Treatment Referral	13 (16.3)	10 (12.7)	6 (9.0)
Patients transitioned to standard of care	--	--	53 (66.3)*

*Transitioned after 24 months









Challenges for Care Integration

Providing care in a rural area

- Lack of transportation & longer commutes

Funding resources & lack of affordable/adequate housing

- Long waitlists for government housing (HUD/HOPWA)
- Private housing opportunities unaffordable
- Lack of centralized data system for non-medical/behavioral resources

Lack of community-based programs

- Few programs and/or interventions geared towards assisting PLWHA, e.g. support groups

Patient-level barriers

- "Hidden-homelessness": unaware of homeless status
- Retention of self-management strategies
  - Maintaining skills, tools and resources from the program, e.g. disclosure conversations and medication adherence
  - Appointment and medication compliance
- Perceived stigma around:
  - HIV/AIDS
  - Needing public assistance

Successes in Care Integration

Community Presence

- Notable presence of the NC REACH/CWH team at community meetings and events
- Community based education about "hidden homelessness", HIV, ART, prevention, discrimination and stigma

Community partnerships, engagement, and advocacy

•**CommWell Health Community Housing Coalition:** housing agencies, landlords, United Way, faith-based organizations, Vet Affairs, Red Cross, Salvation Army,

Sustainability - Next Steps for CWH

- Incorporating the NN/CCC in future care strategies
- Maintaining community partnerships
- Community Housing Coalition Luncheon

Acknowledgments

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